Maine Strategic Prevention Framwork

State Incentive Grant (SPF SIG) Application

Abstract

Through extensive collaboration at both state and local levels, Maine's Strategic Prevention Framework State Incentive Grant will build a statewide data-driven prevention infrastructure that provides common tools/supports for prevention and health promotion programs; creates unified governance structures for local programming and regional prevention support centers; and provides funding for local evidence-based substance abuse prevention programs statewide.

The State of Maine is poised to institute broad and far-reaching changes in its prevention infrastructure in order to coordinate, deliver, sustain, and evaluate evidence-based prevention services. The 2001 National Household Survey on Drug Abuse (NHSDA), published by SAMHSA, as well as other in-state data sources, demonstrate that Maine's most extensive substance abuse problems are with alcohol, marijuana and cigarettes. On these three substances, Maine's prevalence rates are consistently and substantially higher than the national average. Maine's youth (age 12 to 17) and young adult populations (age 18 to 25) are at particularly high risk.

Maine currently lacks a consistent sub-state level infrastructure for prevention. Government is town-based and the state-level prevention/health promotion structure has historically been split across different executive departments. This year Maine has an important opportunity for coordination and infrastructure building because the state's two largest social service departments will merge. Planning for the new Department of Health and Human Services is clearly focused on improving Maine's health care system (including a strong focus on prevention), and on reducing costs and increasing cost-effectiveness through more effective coordination of service delivery systems. The timing and design of this SPF-SIG are just right to help the newly merged department translate these goals into action.

The Advisory Council will be the Children's Cabinet, chaired by First Lady Karen Baldacci. Many state partners collaborated to design the proposal, and are committed to participating in the infrastructure and planning work that will take most of the first two years of the grant.

The project is designed to serve the following purposes: 1) ensure that every community in Maine has the opportunity to participate in a comprehensive needs, resources, and readiness assessment; 2) develop a cross-disciplinary prevention plan grounded in the Strategic Prevention Framework's five steps and six principles; 3) cultivate a skilled prevention workforce across the state; 4) engage all stakeholders in developing, implementing and evaluating local and state prevention plans; 5) implement evidence-based and culturally competent prevention programs, policies, and practices based on epidemiological analysis/needs assessment; 6) evaluate results and communicate them to policymakers and the public; 7) efficiently manage multiple streams of prevention funding to achieve the targeted outcomes linked to each funding source, maintain accountability for both fiscal and programmatic expectations, and address the needs prioritized by each community; and 8) develop long-term sustainability.

Section A: Statement of Need

The Need to Implement the Strategic Prevention Framework in the State

Maine's serious substance abuse problem has received increasing recognition in recent years across the whole spectrum of stakeholders at the state and local levels. As the following snapshot demonstrates, Maine's prevention needs assessment leaves little doubt about the serious nature of Maine's substance abuse problem. The Summary Findings of the 2001 National Household Survey on Drug Abuse (NHSDA), published by SAMHSA, provide the following estimates for Maine:[i]

	AGE 12-17		AGE 18-25		AGE 26 +	
Past month use:	Maine	U.S.	Maine	U.S.	Maine	U.S.
Binge alcohol (5+drinks in a row)	12.8%	10.5%	46.3%	38.1%	20.4%	18.9%
Marijuana	11.1%	7.6%	23.5%	14.6%	4.2%	3.1%
Cigarettes	14.1%	13.3%	45.2%	38.6%	24.9%	24.2%
Any illicit drug other than marijuana	5.7%	4.8%	8.9%	6.9%	1.7%	1.9%

These data demonstrate that our most extensive substance abuse problems are with alcohol, marijuana and cigarettes. On these three substances, Maine's prevalence rates are consistently and substantially higher than the national average. Maine's youth and young adult populations are at particularly high risk compared to the rest of the adult population.

The Maine Office of Substance Abuse (OSA) conducts a biannual statewide student survey on drug and alcohol use. OSA uses the Maine Youth Drug and Alcohol Use Survey (MYDAUS), based upon the risk and protective factors developed by David Hawkins and Richard Catalano at the University of Washington's Social Development Research Group. County-level data is available for both prevalence estimates and risk/protective factors, and OSA has analyzed county-level profiles to identify particularly "high-need" areas of the state. Participating school districts receive a full report of their local data, which they use as the centerpiece of their own local needs assessments, adding other data such as the Search Institute's Developmental Assets survey and local law enforcement data. In 2002, 56,719 surveys were completed from 270 schools in all 16 counties, a response rate of 47.8%. In the past month, 30.3 % of the sixth to twelfth graders reported use of alcohol (16% reported binge drinking in the past 2 weeks), 17.1% reported using marijuana, and 15.2% cigarettes. Current use of each substance increases with age, and peaks at twelfth grade at 29.5% for binge drinking (2 weeks), 28.8% for marijuana (30 day), and 26.1% for cigarettes (30 day).

Maine's MYDAUS also provides a profile of risk and protective factors across the state and in each county for each grade level. Tenth graders consistently have scored worst on most of these scales, suggesting that more efforts should be targeted directly at that age group. The table below highlights some of Maine's priority risk and protective factors based on the 2002 MYDAUS:[ii]

Top Risk Factors	Lowest Protective factors
Rewards for antisocial involvement (56.1%)	Community rewards for involvement (44.7%)
Low school commitment (50.4%)	Community opportunities for involvement (48.3%)
Sensation seeking (47.7%)	Family attachment (53.1%)
Lower academic achievement (46.5%)	Family opportunities for involvement (55.7%)
Poor family management (46.1%)	School rewards for pro-social involvement (57.3%)
Perceived availability of drugs (42.9%)	Family rewards for involvement (58.2%)

In 2002, OSA initiated a phone survey of a random statewide sample (N=500) of parents of eighth to twelfth graders to assess parenting attitudes and behaviors connected to underage drinking. Using questions specifically worded to allow comparisons to the behaviors reported by the youth, the survey found that parents drastically underestimate the likelihood that their own child was using

alcohol (2% thought their own child had used alcohol in the past month vs. 38% of 8-12th graders who reported 30 day alcohol use) and overestimate the likelihood that if their child drank without their permission, they would catch him/her (90% said yes vs. 46% of 8-12th graders who said their parents would catch them).

Recently, we have begun analyzing the prevention needs of the adult population as well. Last year OSA partnered with the Bureau of Health and the University of Southern Maine to analyze the alcohol section of the Behavior Risk Factor Surveillance System (BRFSS), a CDC-sponsored annual phone survey of a random sample of adults. This analysis reveals a young adult population in crisis; for example, 63% of male students aged 18-24 reported binge drinking in the past month. In 2003 and 2004, the CDC selected some states, particularly those with above-average binge drinking rates, to pilot an additional 6-question "binge drinking module." According to the CDC's researcher leading the study, among the 13 states, Maine had the highest average number of drinks consumed per binge drinking episode (9.1). There is much more information to be gleaned from the BRFSS; the SPF-SIG grant will allow us to build our capacity for epidemiological analysis in order to better target prevention services among priority populations.

The Need for an Enhanced Infrastructure

Maine's prevention system has suffered significantly from insufficient infrastructure. Unlike other states, Maine has virtually no sub-state-level public health system with the exception of two city public health departments. We are rural, with a population the size of Greater Boston (1.3 million) spread across a geographic area larger than the other five New England states combined. Our largest city has just over 60,000 people, and only 17 municipalities in the state are larger than 10,000. With a population density of 41 people per square mile (half of the national average), we face substantial barriers to social service delivery and prevention infrastructure development. At the same time, we rank 40th in the nation in median household income (U.S. Census, 2004) and a constitutional requirement for a balanced budget has driven massive state budget cuts in the last several years.

Maine's local government is town-based. Most responsibilities for providing services fall on the shoulders of the state and municipalities, with limited county-level government and an almost complete absence of regional infrastructure. Typically, different state agencies have used a competitive Request for Proposals (RFP) system to distribute relatively small, usually time-limited, grants for local delivery of specific types of prevention services. For example, OSA funds substance abuse prevention services largely through CSAP's Substance Abuse Prevention and Treatment Block Grant 20% Prevention Set-aside. OSA's grants have traditionally been awarded to local non-profits or coalitions that first identify their service area (often one town or several towns) and then provide data on their needs. We lack a truly data-driven distribution process based on epidemiological analysis that objectively assesses needs and resources across the entire state.

Just as OSA has set up its own funding distribution system, the other state agencies have done the same, each creating a local prevention infrastructure for its own targeted health/safety risk area. The result is that local non-profits and coalitions must scrape by using whatever funding they can win to satisfy the short-term categorical objectives rather than develop a sustainable long-term plan to address prioritized community needs. As a result, the "blanket" of prevention services across the state has more holes than threads, and the "survival-of-the-fittest" approach limits capacity-building for many geographic areas of the state. At the local level, four basic scenarios have emerged, all of which create frustration for different reasons:

Scenario	Current Structures/Resources	Frustrations Experienced
Underserved areas	receive little or no state/federal funding for any prevention programs, have developed little local prevention infrastructure; probably have no local prevention coalition.	Lack of infrastructure to compete successfully for prevention funding Sometimes perceive that the state is not interested in investing in local prevention in their area.
Fragmented areas	receive some funding from one or more state programs; grants from different funding streams go to different agencies/ coalitions, who work in isolation; geographic service areas are often inconsistent across different grants.	Vague understanding that prevention programs aren't working as effectively as they could be Occasionally recognize the lack of coordination when grantees doing similar work in the same geographic area learn about each other for the first time
Coordinated areas	receive funding from multiple state programs, with funded agencies/coalitions starting to work together to coordinate plans and services. This category is perhaps the most common now.	Recognize the need to coordinate and have started to do so, but are aware of the barriers. Vigorously protest wasted time spent trying to meet similar expectations from different funders
Early Unified Governance Structure (UGS) prototypes	sizable geographic areas (multiple towns or whole counties) that have begun to bring multiple coalitions/ agencies with overlapping goals together under a shared umbrella, developing shared functions across prevention disciplines, such as needs assessment, data collection/dissemination, strategic planning, fiscal/grants management, grant-writing.	still frustrated but more hopeful (in part because they have been able to access substantial resources and do some creative local weaving of resources Frustration sometimes compensated by gratification in being able to reach considerably more community members with a variety of prevention services.

In addition to the lack of a consistent and sustainable infrastructure, other barriers need to be addressed. Our prevention system has focused largely on children and youth, devoting few resources to improving the health and safety of Maine's young adult population (i.e. age 18-24). Some progress has been made in partnering with colleges to work on specific health risk areas (i.e. alcohol, tobacco, sexual assault) but this work is not coordinated across health areas and there have been few specific prevention efforts for non-college students. Maine's growing elderly population also needs more attention regarding substance abuse and its interconnections with other health risks.

Another gap is our limited understanding of the unique needs of specific cultural groups within the state. Although Maine's population is 96% white, we have increasingly recognized cultural communities who suffer health disparities and whose needs we do not understand well enough to ensure that culturally competent prevention services are available. For example, we need to learn more about the prevention needs of the growing refugee and immigrant communities in urban areas like Lewiston, Biddeford, and Portland (where 53 languages are spoken in the public school system), as well as Maine's four federally recognized Indian tribes. Other subpopulations who are less visible and more dispersed include the gay/lesbian/bisexual/questioning/trans-gendered community, the Deaf community, people living in extreme rural poverty, and people with low literacy skills.

One final gap is worth noting: historically, Maine's single state substance abuse agency (OSA) and the state public health agency (Bureau of Health) have been located within different executive departments and as a result have suffered from a lack of coordination. As of July 1, 2004, those two departments have been merged into the new Department of Health and Human Services. With the Governor's priorities clearly focused on improving Maine's health care system (including prevention) and reducing costs through more effective coordination of social service systems, the timing of this SPF-SIG is just right to help the newly merged department translate goals into action.

How the SPF-SIG will help the state and communities to address substance abuse problems. Maine's prevention system is at a crossroads. With high prevalence rates for certain high-risk behaviors, increasingly limited prevention resources, and the absence of a local/regional prevention infrastructure, we recognize that we cannot simply continue our traditional piecemeal approach. We desperately need a systemic approach to overcome these barriers. The additional capacity built by the SPF-SIG will allow us to reform the distribution of funds and build a sustainable system that is truly data driven, providing both the data and the infrastructure to support its use.

Key stakeholders and resources within the State that can help implement the SPF. The key stakeholders for implementing the SPF are the state partners responsible for prevention and health promotion: Maine Office of Substance Abuse (OSA) (substance abuse); Maine National Guard (drug demand reduction); Maine Higher Education Alcohol Prevention Partnership (college drinking); Bureau of Health (tobacco, physical activity, nutrition, teen/young adult health, intentional and unintentional injury, community health promotion); Division of Children's Services (mental health and developmental services); Refugee and Immigrant Mental Health Collaborative (mental health/acculturation issues); Juvenile Corrections Services (juvenile delinquency prevention and juvenile drug courts); Maine Department of Education's 21st Century Community Learning Grants (after school programs, mentoring, tutoring); and Maine Children's Trust (child abuse and neglect).

Additionally, the following four state organizations are key stakeholders who work more broadly across health areas, focusing on cross-disciplinary capacity building processes that are very much in line with the SPF five steps and six principles***: Communities for Children and Youth*** (an initiative of the Children's Cabinet) – provides technical assistance to community coalitions, has developed expertise in positive youth development and the Developmental Assets approach as mobilization tools**.** ***Coordinated School Health Program*** (Bureau of Health and Department of Education)— provides Coordinated School Health framework and approach, technical assistance, and supports a network of school health coordinators**;** ***Community Healthy Promotion*** (Bureau of Health)— provides small grants and extensive technical assistance to place-based health coalitions that use the Healthy Communities model; ***Maine Center for Public Health*** – has developed expertise related to public health infrastructure, especially analysis of needs/gaps and infrastructure development.

In addition to the above-named state stakeholders who were all involved in the development of this proposal, discussions will continue with additional potential partners representing the following: the Attorney General's Civil Rights Teams Project, the Bureau of Elder and Adult Services, the Maine Coalition to End Domestic Violence, the Maine Coalition against Sexual Assault, the United Way; and the Bureau of Health's bioterrorism and emergency preparedness initiatives.

Section B: Proposed Approach

Purpose /Goals/Objectives

The purpose of Maine's SPF-SIG project is to create and support a statewide prevention/health promotion infrastructure that will:

- Ensure that every community in Maine has the opportunity to participate in a comprehensive needs, resources, and readiness assessment, and develop a cross-disciplinary prevention plan grounded in the SPF 5 steps and 6 principles
- Cultivate a skilled prevention workforce across the whole state, with both core competencies and relevant specialty training
- Engage all stakeholders in developing, implementing and evaluating the prevention plan

- Implement evidence-based and culturally competent prevention programs, policies, and practices based on epidemiological analysis/needs assessment
- Evaluate results and communicate them to policymakers and the public
- Efficiently manage multiple streams of prevention funding in order to achieve the targeted outcomes linked to each funding source, and maintain accountability for both fiscal and programmatic expectations and for addressing the needs prioritized by the community
- Develop long-term sustainability

Figure 1 (next page) shows the existing system of supports for local prevention programming and Figure 2 shows the statewide prevention/health promotion infrastructure proposed in this application.

Goals:

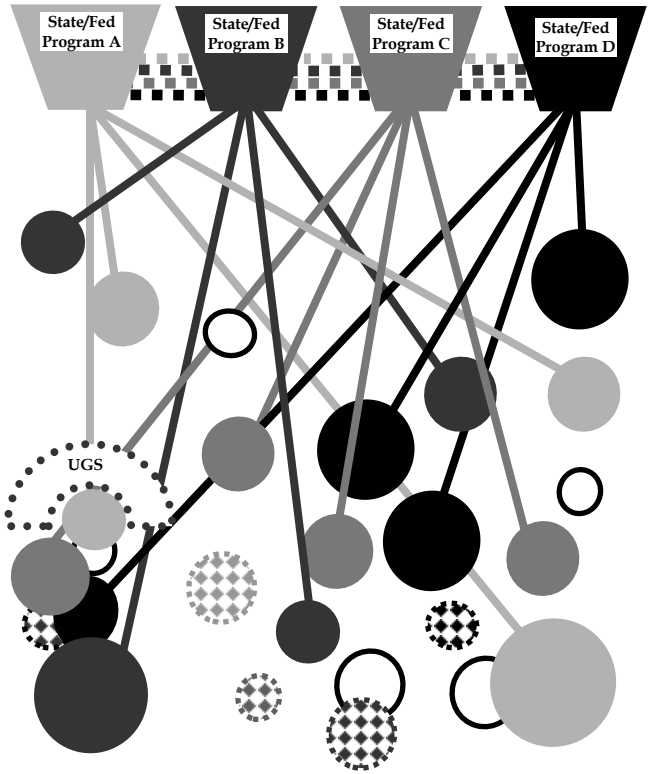
1. Reduce substance abuse (see specific objectives below)
2. Reduce risk factors with demonstrated link to substance abuse and related problems
3. Increase assets and protective factors with demonstrated link to the reduction of substance abuse and related problems
4. Reduce health risk behaviors linked to substance abuse that are priority objectives of the SHY workgroup partners.

Infrastructure/capacity objectives:

1. Identify "high-need" areas/subpopulations within the state, based on epidemiological analysis specific to substance abuse, -relationships across high-risk behaviors, and the capacity of existing local prevention service delivery systems.
2. Develop state-level common tools for use across partner state programs (See Figure 2). The Strategies for Healthy Youth (SHY) Workgroup will lead the development of:
   - a format for local needs assessments and strategic plans based on the SPF
   - a plan for supporting local Unified Governance Structure (UGS) infrastructure and Regional Prevention Support Centers.
   - coordinated funding distribution/accountability processes at state level that will: 1) achieve geographic distribution of local coalitions (many with strong UGS structures) and regional prevention support centers; 2) coordinate grant/contract monitoring processes across prevention- related funding streams for programs represented on SHY Workgroup; 3) streamline state expectations of local grantees to reduce confusion and redundancy; 4) fund implementation of evidence based practices to promote positive youth development and reduce specific health problems based on epidemiological analysis; and 5) maintain accountability for the requirements of federal/state/private funding sources and evaluate/track results.
3. Increase the number of communities that coordinate funding from multiple state programs/agencies to support broad cross-disciplinary strategic prevention plans.
4. Increase the number of communities implementing evidence-based substance abuse prevention programs, practices, and policies
5. Develop and implement a cross-disciplinary Prevention Workforce Development Plan, including: core prevention competencies and a cross-disciplinary training system for Prevention Specialists, that incorporates both generalist and specialty training opportunities

FIGURE 1:

Existing Support System

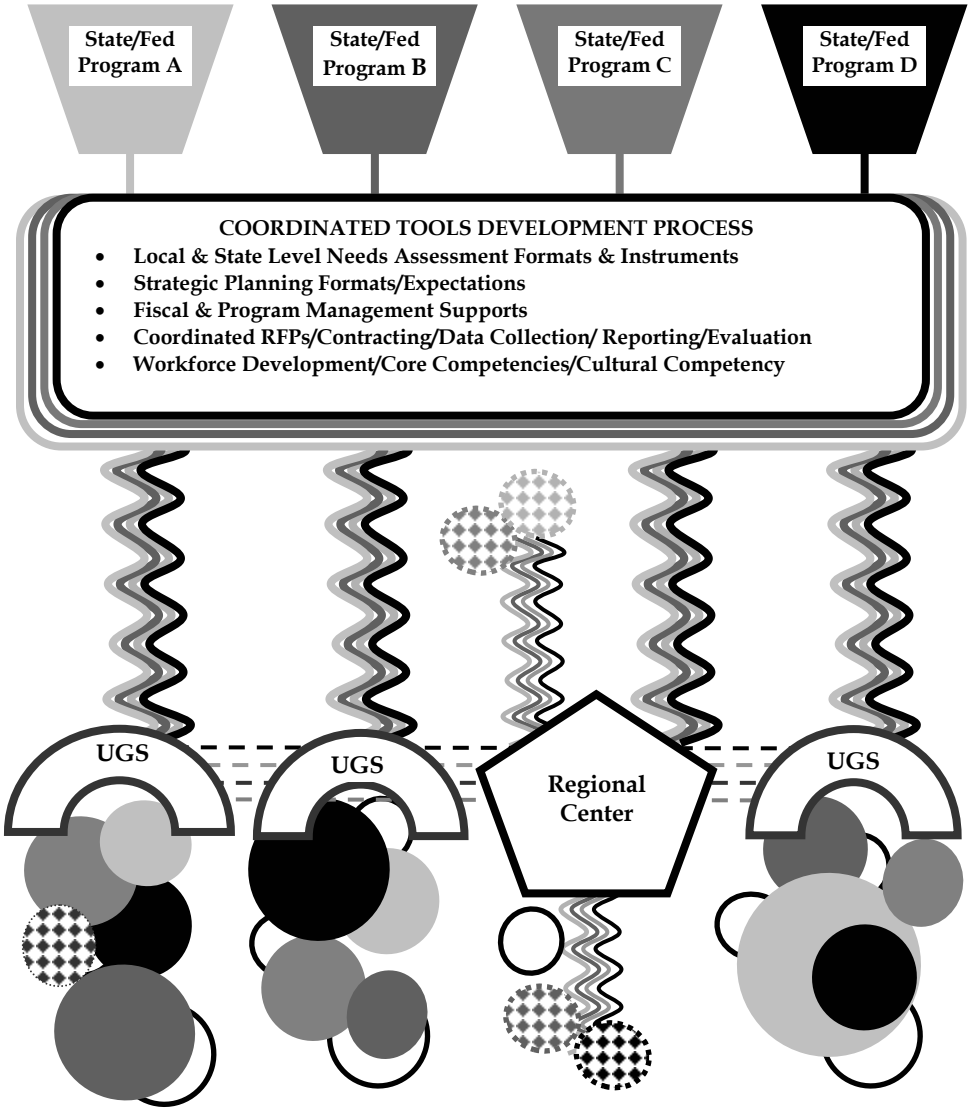


KEY

Solid color = established state/federal programs at state and local levels
Trapezoid = state level **Circle** = local level
Patterns = programs that are organizing
No color = locally funded programs
Arc shape = Unified Governance Structure
Pentagon = Regional Center

FIGURE 2:

Proposed System for Supporting Local Prevention Programming



Substance Abuse Specific Objectives: (measurement tools are discussed in Section D)

	Short-term/Intermediate objectives	Outcome objectives
Binge Drinking	• Decrease perceived ease of access to alcohol among 6-12th graders • Increase perception of consistency of underage drinking enforcement • Decrease gaps between parental knowledge and their children's behavior • Increase perceived risk of binge drinking	• Reduce 2-week binge drinking among 6-12th graders • Reduce average age of first drink among 6-12th graders • Reduce 30-day binge drinking among 18-24 year olds
Tobacco Use	• Increase perceived risk of regular/heavy smoking • Decrease perceived access to tobacco	• Reduce 30-day cigarette use among 6-12th graders and 18-24 year olds
Marijuana	• Increase perceived risk of regular marijuana use among 6-12th graders	• Reduce 30 day marijuana use • Reduce heavy marijuana use (6+ occasions in past 30 days)
All substances	• Decrease priority risk factors • Increase priority assets and protective factors (to be identified by epidemiological analysis)	• Increase proportion of 6-12th graders who report no lifetime and no 30-day use of any substances

The key to making progress on the substance-abuse specific outcomes, both during the five-year grant period and beyond, is developing the solid prevention infrastructure. The six principles of the SPF are fully embedded in the proposed infrastructure. While Maine's first SIG has resulted in great progress, infrastructure development has only begun. Without continued efforts we risk losing the momentum gained and will soon revert to previous patterns: a short-term mentality with prevention service providers forced into competing for unsustainable, time-limited funds.

The Five Steps

	State Level	Local Level
Step 1: Assess	Epidemiological Analysis, including GIS mapping of service provision, local infrastructure, and prevalence/risk/ protective/assets data; identification of underserved geographic areas and substance-abuse-related health disparities of specific sub-populations (Year 1, months 1-9)	Local one-time grants to develop 8 case studies of early "Unified Governance Structure" (UGS) prototypes to document their development process and structures, barriers, challenges, and lessons learned, and share their learnings with others (Year 1-2, months 4-20)
	State-level assessment of prevention/health promotion infrastructure, and identification of needs for regional infrastructure development (Year 1, months 1-9, and ongoing)	Local one-time grants for needs/resources/ readiness assessments: (Year 1-2 months 10-20) 1. Underserved geographic areas 2. Unique cultural groups/communities
Step 2: Mobilize	Continued development of SHY Workgroup and related subcommittees (Ongoing, with intensive work in Year 1 months 1-12)	Creation of Regional Prevention Centers to mobilize prevention efforts in underserved areas and to support ongoing prevention efforts in all communities (Year 1-2 months 7-24 and revised/ renewed Years 3-5)
	Interconnection and coordination with other statewide programs and organizations with overlapping goals and objectives (Ongoing)	Integration of asset-building, Coordinated School Health, and Healthy Communities processes/approaches (as appropriate) as shared functions of regional and UGS infrastructure design
Step 3: Plan	Development of common tools for local prevention grantees - see below for SHY Workgroup responsibilities (Intensive in Year 1, also ongoing)	Local one-time planning grants for the development of UGS structures and strategic prevention plans (Year 2, months 13-20)

	State Level	Local Level
Step 4: Implement	Implementation of coordinated state plan for the distribution of appropriate prevention funds (Year 2, starting July 1 2006 through Year 5 and beyond)	Local Implementation grants 3-year grants to local grantees (as identified by epidemiological analysis) and Regional Prevention Centers (Year 2, starting July 1 2006 through Year 5 and beyond)
Step 5: Evaluate	Evaluation of state-level progress on Steps 1-4 (process evaluation), and evaluation of statewide substance abuse outcomes (Year 1-5)	Evaluation of local-level progress on Steps 1-4 (process evaluation), and evaluation of local infrastructure and substance abuse outcomes (Year 1-5)

Underage Drinking as an emphasis in target communities

Maine's Underage Drinking Strategic Plan, primarily funded by OJJDP's Enforcing the Underage Drinking Laws Program (EUDL), will be woven into SPF-SIG. The EUDL State Coordinator will ensure that activities are well coordinated on the SPF-SIG, as she has with Maine's first SIG. SPF-SIG builds on current work using environmental strategies to address underage drinking. Policy and enforcement strategies have emerged clearly in the research, most recently in the National Academy of Sciences Report on Underage Drinking, as effective means of reducing underage and high-risk drinking. These are central to both our OJJDP underage drinking strategic plan and our SIG, with 14 of the 23 One ME coalitions selecting Communities Mobilizing for Change on Alcohol or the Community Trials Initiative as one model programs. In addition, Maine's Higher Education Alcohol Prevention Project developed a college-specific layer of the statewide strategic plan, based on evidence-based practices identified by the NIAAA's Task Force on College Drinking (2002).

OSA has developed solid relationships with the Department of Public Safety, the Attorney General's Office, and many local law enforcement agencies. One initiative, the Youth Empowerment and Policy Group (YEP), consists of 22 youth who have spent the past 3 years analyzing alcohol policy in Maine. As a result of YEP recommendations, a workgroup spearheaded by the Attorney General's Office is now developing a comprehensive model police department policy on underage drinking that will be promoted statewide. This initiative will be coordinated with the implementation phase of the SPF-SIG. Presuming that the epidemiological analysis confirms what we have learned from the MYDAUS data, i.e. that "laws and norms favorable to substance use" is one of our top risk factors, we have identified consistency of enforcement as one of our intermediate objectives and plan to require that subgrantees receiving implementation funds in Step 4 build policy/enforcement strategies, such as working with local law enforcement to consider the YEP recommendations and adopt a written underage drinking policy based on the model, into their strategic plans.

Epidemiological Workgroups

Our approach to the epidemiological component of the SPF-SIG includes the following:

1. The Office of Substance Abuse will use an established partnership that provides epidemiology expertise for the Bureau of Health, in order to contract with the University of Southern Maine to hire a full-time PhD-prepared Substance Abuse Epidemiologist. This person will work closely with OSA as well as with the Bureau of Health and the other state partners, to analyze the available data related to substance abuse and its interconnections with other health outcomes. This will include Maine-specific (state/local) data, as well as the research literature on relationships among health risk areas.

2. The SPF-SIG Epidemiologist will also work closely with the existing "Internet Mapping for Communities" (IM4C) project, which is already in the process of building an internet-mapping system that will allow communities to use GIS maps to examine their MYDAUS data and other

health risk behavior data. The Epidemiologist will develop methods to input information on local prevention infrastructure/service delivery into the IM4C system and align prevalence and risk/protective factor data with this information to identify gaps in our current system.

3. The Epidemiologist will work with three existing workgroups. The first is Maine's "Community Epidemiology Surveillance Network," a substance abuse epidemiology workgroup which was established according to NIDA's epidemiology surveillance model (NIDA 1998) with technical assistance from the CSAT. The second is the Bureau of Health's "Epi Team" which consists of all of the epidemiologists assigned to the Bureau's community and family health programs. The third workgroup is led by the Maine Center for Public Health and addresses questions related to the similarities and differences between epidemiology and evaluation in the field of public health.

4. The Epidemiologist will work closely with Hornby Zeller Associates, the evaluation consultant, especially after the initial wave of needs assessment in the first year.

SPF Advisory Council

The Governor's Office has acknowledged that this project is of significant importance and must be well integrated into the state system. Thus, he has asked his Children's Cabinet to serve as the Advisory Council. The Children's Cabinet is authorized in statute with a purpose of "collaborating to create, manage, and promote coordinated policies, programs, and service delivery systems." Chaired by the First Lady, Karen Baldacci, it is composed of the executives of each of the departments listed below, and meets quarterly; senior staff to these executives meet weekly as well: Department of Education, *Commissioner, Susan Gendron;* Department of Human Services,[iii] *Commissioner, John R. Nicholas*; Department of Public Safety*, Commissioner, Michael Cantara*; Department of Corrections, C*ommissioner, Martin Magnusson*; Department of Labor*, Commissioner, Laura Fortman*; State Planning Office, *Maryalice Crofton*; Communities for Children & Youth, *Executive Coordinator, Susan Savell*; Muskie School, Institute for Public Sector Innovation, *Freda Bernotavicz.*

As the Children's Cabinet will be unable to devote time to the day-to-day oversight of the project, they will designate for that role the existing Strategies for Healthy Youth (SHY) Workgroup which originated with Maine's first State Incentive Grant. The DEA Demand Reduction Coordinator for northern New England has also agreed to join this group.

The Strategies for Healthy Youth Workgroup (SHY) will establish common tools to be used across state programs. SHY will establish time-limited subcommittees to tackle different pieces of its agenda. The SHY Workgroup will serve as the communication link between any subcommittees and the Advisory Council, which will provide input into the development of the common tools and approve the strategic prevention plan prior to submitting it to CSAP for approval. Listed below are the SHY Workgroup responsibilities:

1. Assess state prevention, health promotion, and positive youth development infrastructure
2. Develop cross-disciplinary components of the State Strategic Prevention Plan:
    - Develop consensus on minimum outcomes to be tracked that incorporate all of the relevant health risk and health promotion areas
    - Develop consensus on geographic regions, eligibility criteria, and expectations for Regional Prevention Support Centers
    - Develop consensus regarding desired size, service area, and service population for local UGS structures and a distribution plan for UGS planning grants

- Develop common program planning tools/formats for local use (i.e. needs assessment, strategic plan, evaluation)
- Develop common expectations and support systems for grant/fiscal management functions (i.e. RFP coordination, contract templates, reporting systems)
- Develop core competencies and prevention workforce development plan (already begun)
- Develop shared and/or coordinated data systems
- Develop agreement on a common format for the specific components of the state prevention plan to be inserted by the relevant state partners (i.e. the substance abuse prevention component of the plan will be developed by the Office of Substance Abuse)

In addition to the epidemiology workgroup, the SHY Workgroup will coordinate efforts with several existing groups including the Legislative Youth Advisory Council and/or its Substance Abuse Subcommittee (described below); the Student Survey Committee (under the leadership of the Department of Education, a cross-agency committee working on merging existing student surveys into a single instrument); and a new cultural competency workgroup forming within the new Department of Health and Human Services.

Plans to implement culturally appropriate policies, programs, and practices

Several components of this proposal are designed to increase our capacity at both the state and local level to implement culturally appropriate policies, programs, and practices.

1. The epidemiological analysis will focus special attention on health disparities across various racial/ethnic and other cultural groups, and on the inter-relationships between substance abuse prevalence/risk and protective factor rates and other areas of health disparities (i.e. chronic disease, disproportionate minority contact in the juvenile justice system, etc).
2. A set of grants early in the project will be awarded to conduct needs/resources/readiness assessments among specific cultural subpopulations, including both racial/ethnic communities and other cultural groups as described in Section A. These grants will require that the leadership be provided by members of the communities being studied. Beyond the assessment component, grantees will develop recommendations for local prevention coalitions to help them better serve the needs of the identified cultural group. These grantees will work with both the Regional Prevention Support Centers and local coalitions during the strategic planning grants phase to assist them in integrating the needs of specific cultural groups into their strategic plans. These grantees may also serve as consultants during the Implementation phase, as coalitions work on the cultural tailoring of evidence-based programs for particular target populations; it will be a requirement of programming grants that funds be budgeted specifically for this purpose.
3. Two tools already identified by the SHY Workgroup will be examined for potential inclusion in the set of common tools developed as part of the state infrastructure. One is the National Center for Cultural Competence's *Self-Assessment Checklist for Personnel Providing Services* designed to increase sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings (Goode, 2002). The second is the *Community Readiness Assessment* created by the Tri-Ethnic Center for Prevention Research, a tool whose purpose is to promote community self-understanding and develop effective, culturally-appropriate, and community-specific strategies for prevention and intervention (Plested, 2004).
4. One of the core competencies already identified by the SHY Workgroup is cultural competence. Trainings on cultural competence, and the infusion of cultural competence into other training topics, will be a component of the Prevention Workforce Development Plan. We will request

technical assistance from the Northeast CAPT and/or other organizations with national expertise in this area to design this component of the plan effectively.

How communities will be encouraged to use evidence-based programs, practices, and policies

For each of the five steps, the focus at both the state and local level will be on identifying programs, practices, and policies that are grounded in research and that demonstrate positive outcomes. In the past few years we have increased our focus on evidence-based programming, and will continue to do so. Development of the proposed prevention infrastructure, however, will help us ensure that evidence-based programs, policies, and practices are available *across the entire state* for a broad range of prevention services. The design of the local grants will encourage/require communities to use evidence-based programs, policies, and practices in the following ways:

1. For planning grants, the local strategic prevention plans will be expected to: apply multiple strategies in multiple domains; build assets and resiliency; use both environmental and individual strategies; incorporate universal, selective, indicated strategies; and develop coordinated layers of both positive youth development (i.e. youth empowerment, asset building) and evidence based programs proven to reduce specific health-risk behaviors (i.e. substance abuse, unprotected sex, bullying) and promote specific healthy behaviors (i.e. physical activity, nutrition).
2. For implementation grants awarded to "high-need" areas based on epidemiological analysis, the substance-abuse-specific components of grantees' strategic plans will be required to use the risk and protective factor framework for their local substance abuse needs/ resources assessment component to guide the selection of evidence-based programs.
3. The Workforce Development plan will include training on skills necessary for the selection, adaptation, implementation, and evaluation of evidence-based prevention programs.
4. Hornby Zeller Associates, the evaluation consultant on Maine's current SIG project (One ME) who is also proposed as the evaluator for this project, will prepare a plan by October 2005 for the dissemination of the extensive information that will be available in early 2006 regarding implementation lessons and outcomes of the evidence-based programs funded by One ME.

Community partners and other partner organizations

Most of the specific community partners who will receive SPF-SIG funding cannot be identified prior to the state-level work that will target the local funding. Even the geographic divisions for the regional prevention support centers and the eligibility criteria for organizations to serve as centers must be developed by the SHY workgroup. The community partners will come from the web of existing local programs/coalitions linked to the state partners who developed this proposal:[iv]

Network of local coalitions/ programs	State agency funder/guide (and federal funding source)	# state wide	Purpose/goals	Resources available to communities	Typical fiscal/ management agent
One ME	OSA (SAMHSA/ CSAP)	23	Reduce binge drinking and tobacco use; develop sustainable substance abuse programming	Funding, training, technical assistance	Coalitions, substance abuse agencies, schools, other
Healthy Maine Partnerships	Bureau of Health (CDC and Fund for Healthy Maine)	31	Reduce tobacco use, increase physical activity and improve nutrition	Funding, training, technical assistance	Hospitals

Communities for Children	Children's Cabinet (State funding)	73	Positive youth development, build assets, broad healthy outcomes for children and youth, increase educational attainment	Training & technical assistance, minimal direct local funding, grant writing, VISTA volunteers	Mixed
Coordinated School Health Programs	Bureau of Health/Dept of Education (CDC grant)	54	Develop comprehensive coordinated school health plan	Training & technical assistance, grants	Schools
Healthy Communities	Bureau of Health (Fed preventive health block grant)	22	Comprehensive community health and quality of life planning and improvement, using broad definition of health all sectors of community	Mostly training, technical assistance, support, some small planning grants	Mixed
JJAG local grantees	Juvenile Justice, Dept of Corrections	30	Reduce juvenile delinquency	Funding, training, technical assistance	Local law enforcement, municipalities, local coalitions
Underage Drinking grantees	OSA (OJJDP EUDL and US Dept of Ed)	33	Reduce underage and high-risk drinking, increase effectiveness of enforcement, reduce underage access to alcohol	Funding, training, technical assistance	Law enforcement, colleges, Maine Youth Voices groups
Other substance abuse prevention grantees	OSA (CSAP SAPTBG, SDFSCA Governor's portion, Fund for Healthy Maine)	62	Reduce substance abuse and related problems	Funding, training, technical assistance	Non-profit social service agencies, schools, colleges, coalitions, law enforcement
21st Century Learning Program	Dept of Education	18	Establish Community Learning Centers to provide after school programs and enrichment/supports	Funding; training, technical assistance, evaluation, oversight	Local education agencies; community orgs.
Family Life Education / Family Planning Outreach	Bureau of Health (Teen and Young Adult Health Program)	14	Assist schools and communities in ensuring that youth have the knowledge and skills to be sexually healthy and responsible	Technical assistance, materials, some direct educational outreach services	Family Planning agencies

We have already identified eight community grantees for one aspect of the project: the local one-time grants to early "Unified Governance Structure" (UGS) prototypes. These grants are for case studies that will document development processes and structures, and describe barriers, challenges, and lessons learned. Grantees also agree to share their learnings with others. These communities were nominated by the state partners because they have already begun to coordinate their prevention efforts in the way this proposal envisions. To be selected, the local prevention infrastructure had to meet most of the following criteria: be comprised of or collaborating with multiple coalition types; have a comprehensive plan that weaves together multiple health/prevention topics/areas; have conducted extensive and broad-based needs assessment of the defined community; have an active leadership group that includes representatives of a variety of organizations; have demonstrated flexible and positive collaboration; involve youth and parents in governance structure; and have a diversified funding base. The eight local partners are: Farmington Healthy Communities Coalition, Portland Public Health Department, Greater Waterville Communities for Children & Youth, Healthy

Androscoggin County, Healthy Hancock County, Youth Promise of Lincoln County, River Valley Healthy Communities Coalition, and southern York Community Wellness Coalition. They represent a mix of geographic areas, sizes, rural/urban settings, and "coalitions of origin." Each has signed a Letter of Agreement (see Appendix 1).

Target population involvement

Maine prevention advocates pride themselves on their commitment to youth empowerment and the involvement of youth in the development of programs and policies that impact their lives. Voices of youth shaped this proposal in several concrete ways:

1. In 2002, the Maine Legislative Youth Advisory Council (LYAC) was established in statute to "advise the Legislature and its Committees on issues related to youth." The Council, which appears to be unique to Maine, is comprised of three legislative members and 18 youth members, meets at least 8 times each year, conducts at least 2 public hearings each year and an annual seminar each August, reports annually to the Legislature, and is authorized by law to submit legislation (Maine LYAC Report, 2003). In its first year, the LYAC selected substance abuse prevention as its primary focus. In their first annual report to the Legislature in January of 2003 the Council created a 3-member subcommittee of youth members to work with OSA and other state agencies to increase youth involvement in agency policy-making. They further recommended that OSA continue to work with the Council on evaluation of prevention programs and procedures for awarding grants, particularly to assure that funding for effective programs reaches areas with the highest demonstrated need. A draft of this proposal has been reviewed by the LYAC Substance Abuse Subcommittee and a representative of LYAC has been invited to join the SHY Workgroup.

2. The work of the Youth Empowerment and Policy Group regarding enforcement of the underage drinking laws drove the specific focus on police department policies discussed earlier.

3. Youth representatives comprise 30% of the membership of the Communities for Children and Youth Advisory Council, who also provided input into the design of this proposal.

4. A number of the participating state partners already require youth representation in the local prevention program/coalition leadership structures that they fund. Early in Year One, a summit will bring together youth and adult staff representatives of programs that focus on youth involvement, including the Maine Youth Action Network, Maine Youth Voices, the Youth Advocacy Project, the Youth Empowerment and Policy Group, the Civil Rights Teams, and Communities for Children and Youth. The summit will assist the SHY Workgroup to determine needs/potential for incorporating youth empowerment in the SPF-SIG infrastructure design.

Potential barriers to success and plans to overcome them

This is an ambitious plan with numerous barriers to success. Internal barriers include: ongoing changes in state government leadership; the relative instability of financial resources from federal and state government; time limitations for state program staff; varying levels of sophistication, research base, and range of focus within each field, program and department; and sometimes a sense of ownership for specific programs that impedes collaboration. External barriers include pressure from funding agencies to achieve narrow and specific outcomes with different funding streams and the fact that new research constantly changes what we know about what works in prevention.

Our plan to overcome these barriers began with the collaborative development of this proposal by an existing workgroup with a well-established sense of trust and respect, and with repeated opportunities for input at every stage of development from the whole group of relevant agencies. In addition we acknowledge the value of the institutional knowledge among the state stakeholders who

can articulate the lessons learned from earlier attempts at infrastructure development. We will have the support and active involvement of the Children's Cabinet and Governor's Office, and leadership by the First Lady to assure the balance we need. We will align key state infrastructure tasks with the timing of very specific and critical windows of opportunity, such as the merger of the state's two largest social service departments, the launch of the state's Dirigo Health Plan, the re-design of the Healthy Maine Partnerships program, and the re-distribution of most of OSA's prevention funding. We have earmarked funding to hire consultants to facilitate components of the state-level work that wouldn't work if driven by a single agency. We will pay special attention to maintaining our commitment to all of the interconnected outcomes across the entire health and youth development spectrum and to identifying the critical needs/expectations of each state stakeholder. Finally, we will continue monitoring new prevention research and we expect that new evidence-based strategies will evolve over the five year grant period and that our plan will need to be flexible enough to adapt.

Plan to secure resources to sustain the proposed infrastructure enhancements

Building the proposed prevention infrastructure described here is our best hope for securing the financial future of evidence-based prevention Maine. Unless the economy rebounds miraculously, we cannot expect that we will be able to replace the SPF-SIG funding in five years with state funds. Therefore, this plan is not built on a hope for maintaining ongoing funding of the same magnitude, but has been designed strategically to use the timing of the several unique opportunities for collaboration and systems change to develop a prevention infrastructure that will be sustainable once the SPF-SIG funds expire. One such opportunity is the merger of the BDS and DHS under a new commissioner whose mandate from the Governor includes increased cost efficiencies, cost effectiveness, and coordination of systems of services. This coincides with the widespread recognition among our state partners that it is more effective to build a shared prevention infrastructure than to continue to maintain separate overlapping infrastructures.

The infusion of SPF-SIG funds for the initial 21 month period to support local needs assessment, strategic planning, and UGS development will occur ***prior*** to the scheduled re-design of two of the state's largest prevention funding streams (the Healthy Maine Partnerships program and OSA's SAPT block grant and tobacco settlement funds) which provides us a rare opportunity for systems planning. Critical input into the planning phase includes results from Maine's current SIG, which will yield extremely valuable process and outcome data related to both the development of early UGS prototypes and to the optimal conditions for implementing evidence-based programs. Finally, the Governor's Dirigo Health Plan, which includes universal health care coverage, values prevention as a priority strategy for keeping health care costs down. Some of our confidence in the long-term sustainability stems from the fact that the proposed infrastructure is not designed solely for substance abuse prevention. With various state partners sharing the costs of supporting a cross-disciplinary prevention infrastructure, local grantees and regional prevention support centers will be able to draw on a more diversified funding base. This will allow them to devote more energy to the ongoing work of each of the 5 Steps.

Section C. Capability and Experience

The Office of Substance Abuse (OSA) is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse services. The Office provides leadership in substance abuse prevention, intervention, and treatment. Its goal is to enhance the health and safety of Maine citizens through the reduction of the overall impact of substance use, abuse and dependency. OSA was awarded a CSAP State Incentive Grant in 2001 as

part of Cohort V. The SIG (known as One ME) allowed OSA to fund 23 community coalitions, including the Waponahki Prevention Coalition that brought together all of the American Indian tribes in Maine and the Portland Partnership for Homeless Youth--priority populations for OSA. The funding and evaluation of the coalitions has helped clarify the need for the infrastructure proposed in this application and establish strong linkages between state agencies and other funders who also work with coalitions.

The Strategies for Healthy Youth (SHY) workgroup, formed as a result of the SIG, has already done preliminary work in the area of core competencies for prevention providers across departments, and provision of cross-disciplinary trainings and technical assistance. In addition, other partners and/or developments that form a foundation for this proposal include: ***Maine Turning Point Project (Maine Center for Public Health)***--brought together many stakeholders to analyze the need for a regional public health system and accountability structure; ***Fund for Healthy Maine***--designated that all tobacco settlement funds be used for health-related services including substance abuse; ***Maine Youth Suicide Prevention Plan***--interdepartmental effort to address the needs of high risk youth through gatekeeper training, work with schools, and targeted programs; ***Cross-disciplinary Prevention Plan and Think Tank***--representatives from child abuse, domestic violence, juvenile delinquency, sexual assault and substance abuse prevention working to identify barriers and opportunities for cross-disciplinary efforts; ***Merger of behavioral health surveys*** (MYDAUS, YTS, YRBS, and possibly Search Institute's Developmental Assets survey) for coordinated administration in 2009.

OSA currently administers other federal prevention grants including the Substance Abuse Prevention and Treatment Block Grant, the OJJDP Enforcing Underage Drinking Laws (EUDL) Block Grant, Safe and Drug-free Communities Act--both the Governor's portion and the LEA/SEA grant funds, a Community Youth Development Study grant that works with four Maine communities using the Communities That Care model, and a number of treatment grants including two Drug Court evaluation grants. In addition, OSA has received three OJJDP EUDL Discretionary Grants in past years and a competitive Department of Education grant to help reduce high-risk drinking among college students. Outcomes from these efforts have included reductions in problem behaviors and OSA has been able to coordinate and maximize resources in a synergistic way. As the chart below shows, OSA has also been able to serve minority populations in greater numbers than their percentage of the Maine population.

		Total	White	African American	American Indian or Alaska Native	Asian	Hispanic/ Latino	Multiracial/ Multiethnic	Other
2000 US Census[v] demographics of Maine's Racial and Ethnic Maine's Population (are an undercount as they do not include the wave of immigrants who arrived after 2000)	Maine		96.9%	0.5%	0.6%	0.7%	.7%	1.2%	0.7%
	U.S.		75.1%	12.3%	0.9%	3.6%	12.5%	2.4%	18%
Prevention program participants tracked by the Maine PBPS from 7-03 to 6-04 (all grantees funded by SIG and SFDSCA Gov portion):	#	3380	2894	206	92	127	NA	20	41
	%	100%	85.6%	6.09%	2.72%	3.76%	NA	0.6%	1.23%
Proposed primary customers by race/ethnicity for all other OSA-funded Prevention Programs FY 03-04	#	49162	46012	715	876	517	91	431	520
	%	100%	93.59%	1.45%	1.78%	1.05%	.185%	.84%	1.05%

SPF-SIG Project Timeline

State Level Activities and Milestones	Assignment	YEAR 1				YEAR 2				YEAR 3				YEAR 4				YEAR 5			
1. Hire SPF-SIG coordinator and substance abuse epidemiologist.	OSA	**X**																			
2. Identify underserved areas based on epidemiological analysis of needs and resources.	EPI Workgroup	**X**	**X**	**X**	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
3. Assess state prevention and health infrastructure and identify needs for regional infrastructure development.	EPI Workgroup SHY Workgroup	**X**	**X**	**X**	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
4. Recruit additional members and develop the subcommittees for SHY Workgroup	SHY Workgroup	**X**	**X**	x	x	x	x	x	x												
5. Develop common tools for local prevention grantees (See page 9).	SHY Workgroup	**X**	**X**	**X**	**X**	**X**	**X**	x	x	x	x	x	x	x	x	x	x	x	x	x	x
6. Develop cross-disciplinary Prevention Workforce Development Plan	SHY Workgroup		**X**	**X**	**X**	**X**	**X**	**X**	x	x	x	x	x								
7. Develop State Plan for cross-agency use of common infrastructure and coordinated distribution of appropriate prevention funds through Unified Governance Structures.	SHY Workgroup State Programs			**X**	**X**	**X**	**X**														
8. Implement State Plan for cross-agency use of common infrastructure and coordinated distribution of appropriate prevention funds.	SHY Workgroup State Programs							**X**	**X**	x	x	x	x	x	x	x	x	x	x	x	x
9. Coordinate with other statewide programs/organizations with overlapping goals and objectives; maintain participation of youth and ethnic/cultural groups involved in planning.	SHY Workgroup OSA	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
10. Evaluate state-level progress on the first six state activities and evaluate statewide substance abuse outcomes.	Project Evaluator	x	x	x	x	x	x	x	x	**X**	**X**	**X**	x	x	x	x	x	x	**X**	**X**	**X**
Local Level Activities and Milestones																					
1. Provide local one-time grants to early "Unified Governance Structure" (UGS) models to document their development process.	OSA ; Local sites (page 12)		**X**	**X**	**X**	**X**	**X**	**X**													
2. Provide local one-time grant for needs/resources/ readiness assessments for underserved geographic areas and cultural groups/communities.	OSA; Local sites TBA				**X**	**X**	**X**	**X**													
3. Create Regional Prevention Centers to mobilize prevention in underserved areas and support ongoing prevention efforts.	SHY Workgroup OSA				**X**	**X**	**X**	**X**	x	x	x	x	x	x	x	x	x	x	x	x	x
4. Integrate asset-building, Coordinated School Health, and Healthy Communities processes/approaches as shared functions in UGS and regional center design.	SHY Workgroup Local UGS sites				**X**	**X**	**X**	**X**	x	x	x	x	x	x	x	x	x	x	x	x	x
5. Provide local one-time planning grants for the development of UGS models and broad-based strategic prevention plans.	OSA; Local sites TBA							**X**	**X**	**X**											
6. Provide local implementation grants: 3-year infrastructure grants; 3-year grants for evidence-based substance abuse prevention programming.	OSA; Local sites TBA								**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
7. Evaluate local level progress on first five local activities; evaluate local infrastructure development efforts; evaluate local substance abuse outcomes.	Project Evaluator	x	x	x	x	x	x	x	x	**X**	**X**	**X**	x	x	x	x	x	x	**X**	**X**	**X**

KEY **X** Upper case bold = intense activity or development phase
x Lower case = continuing activity, maintenance or implementation phase

Staff and Major Consultants

***Office of Substance Abuse Staff*:**

Kim Johnson, **M.S.** will serve as Project Director on the SPF-SIG. Kim has been Director of OSA for the past four years. During that time she has expanded access to treatment services, increased prevention programming, and collaborated with a variety of other fields including mental health, child welfare and criminal justice. Under her stewardship, service availability grew despite a state budget crisis through expanded federal support. Kim has worked with the Governor's office and legislature to set public policy. She has also worked with local government and community providers to enact policy and develop programming. Kim's time will primarily be spent as the liaison with the Children's Cabinet, the Advisory Council for this project.

Linda Williams, M.A. has overall responsibility for Prevention activities. By meeting regularly with Meredith Fossel and the SPF-SIG Coordinator she will ensure that the two projects are coordinated and that the system being built includes all other Prevention activities administered by the OSA. She will serve as the key staff for the SHY workgroup and spend 25 % of her time on the project.

Rebecca Matusovich, M.P.P.M. as the Enforcing Underage Drinking Laws Coordinator will spend 25% of her time on this project. Her primary role is to help communities to select and implement evidence-based programs that target underage drinking, including environmental strategies.

Geoffrey Miller, M.Ed. will spend 35% of his time on the SPF-SIG. Geoff is the lead trainer and expert on the Performance Based Prevention System (PBPS), a sophisticated data collection mechanism developed by KIT Solutions to monitor the activities of local grantees. Geoff will also work with new grantees on using cultural competence resources.

(The four OSA staff listed just above will provide their time as in-kind on this project.)

Meredith Fossel, M.S. is the One ME--Stand for Prevention (SIG) Coordinator. Meredith will work closely with the new Coordinator to ensure SPF-SIG builds on the lessons learned in One ME.

SPF-SIG Coordinator (to be hired): Master's prepared with significant experience managing complex projects. S/he will have a strong background in prevention, preferably substance abuse prevention, and a good understanding of evidence-based programming and coalition development.

2 SPF-SIG Prevention Specialists (to be hired) will assist with needs and resource assessments, provide technical assistance, staff workgroups/subcommittees, support subrecipients in data collection, program selection, implementation, and evaluation. Qualifications will include knowledge of evidence-based prevention as well as ability to work with various types of coalitions.

Evaluator: **Hornby Zeller Associates, Inc. (HZA).** HZA is a consulting firm specializing in health and human services policy analysis and program evaluation. With offices in five states, HZA's 35 full-time staff members include several Ph.D. statisticians and experts in both quantitative and qualitative analysis. HZA has conducted evaluations, policy analysis and research projects in over 30 states. Its expertise in the evaluation of mental health and social services programs include several funded by SAMHSA.

Dennis Zeller, Ph.D., M.S.S.W., Evaluation Principal Investigator: Dr. Zeller's major areas of expertise include policy analysis, research design, data analysis and computer application development. Prior to founding the consulting firm in 1988, Dr. Zeller was Director of the Bureau of Policy Planning at the N.Y. Department of Social Services. While responsible for policy development and regulations, he also negotiated settlement to litigation regarding foster children preparing for independence in New York City and developed the state's Utilization Review process. Before that he was a planner for the Texas Department of Human Services.

Helaine Hornby, M.A. Evaluation Director: Helaine Hornby is co-founder of Hornby Zeller Associates where she has worked since 1995. Previously she was Director of the Center for Child and Family Policy at the Edmund S. Muskie Institute of Public Affairs at University of Southern Maine and has evaluated social service programs for 25 years. She was also the founder and director for eight years of the National Child Welfare Management Center. Ms. Hornby as served as the principal evaluator for the various SAMHSA evaluations including the current SIG project. Ms. Hornby will manage the SPF-SIG evaluation and will supervise several staff on the project including Barbara Pierce, MA and Bernardo Feliciano, M.Ed., both having experience on the current SIG evaluation.

Coordinator for the statewide Strategic Plan and Epidemiological Workgroup: **Muskie School of Public Service, University of Southern Maine (USM)**. The Muskie School houses three master's programs (health policy and management, public policy, and community development and planning), a doctoral program, and three nationally prominent research institutes in Health Policy, Child and Family Policy, and Public Sector Innovation. The Muskie School has worked very closely for over twenty years with Maine's Departments of Human Services and Behavioral and Developmental Services to improve the coordination and effectiveness of social, health, and behavioral health services to Maine's citizens.

David Lambert, Ph.D. (Associate Professor), teaches in the Health Policy and Management Program within the Muskie School and is the Mental Health Program Leader in the School's Institute for Health Policy. Lambert is currently directing the evaluation of Maine's Family Treatment Drug Court (funded by CSAP) and was the PI of the Evaluation of Maine's Dual Diagnosis Demonstration Project (a longitudinal study of persons with co-occurring mental health and substance abuse problems), funded by the Bingham Program and Robert Wood Johnson Foundation, and was Co-PI on Maine's Consumer Operated Services Demonstration Project (COSP), funded by the Center for Mental Health Services, SAMHSA.

Michael Brennan, M.A., MSW, LCSW, is a Policy Associate within Muskie School's Institute for Child and Family Policy. Brennan authored a report commissioned by OSA, "Child Welfare, Domestic Violence and Substance Abuse: A Report on Protocols and Practices." Brennan is working on multiple projects related to substance abuse, influencing child welfare policy and community planning. Brennan served four terms as state representative in the Maine Legislature, was the House Chair of the Joint Select Committee on Substance Abuse and is now serving in the Maine Senate where he chairs the Senate's Health and Human Services Committee.

Epidemiologist will be selected through a Cooperative Agreement with the University of Southern Maine to work on this project. S/he will be PhD, will function as part of the BOH Epidemiology Team and will be versed in substance abuse. Ability to summarize and explain technical information for multiple stakeholders will be important. S/he coordinate the activities of the Epidemiology Workgroup.

Resources Available

The Office of Substance Abuse will provide a new and reliable work station for the three SPF-SIG staff and a fully furnished office space. There will be a small amount budgeted out of the grant for software, printing and supplies. OSA is accessible to the public including TTY access and interpreter services. Its website is ADA compliant and all publications are available in alternate formats. It is anticipated that some publications will need to be translated into other languages or written in multiple formats to accommodate the 15% of Mainers who are at a low literacy level; the proposed budget includes funding for these services. SPF-SIG staff will have full access to OSA equipment

and resources. OSA has multiple laptops, LCDs and other equipment for presentations and meetings. The Information & Resource Center (IRC) within OSA is the State RADAR center, and houses an extensive lending library of research literature and materials. Among the center's four staff, two are Masters level librarians who consult with providers on their needs and the best materials to complement their programs. The IRC has substantial information about model programs, as well as material about risk and protective factors. The IRC maintains OSA's website with dynamic and fresh content to share information statewide, including links such as www.oneme.org (current SIG information), www.maineparents.net (parent underage drinking multi-media campaign), and (www.maineprevention calendar.org (a multi-program training calendar).

Section D: Evaluation and Data

The work of the epidemiologist and the Epidemiological Workgroup will be complemented by an objective third party evaluation performed by Hornby Zeller Associates, a firm with extensive SAMHSA evaluation experience including the program level evaluation of Maine's SIG. Maine elected to separate the epidemiological and evaluation functions to provide ability for deeper analysis of systems changes. The purposes of the evaluation are:

1. To determine if Maine's desired outcomes have been achieved,
2. To assess program effectiveness and service delivery quality;
3. To encourage needed improvement and to promote sustainability of effective programs.

Maine is prepared to adjust its implementation plans based upon the results of the monitoring and evaluation activities. As demonstrated below, the plan encompasses the required GPRA performance measures as well as the specific targets established for this project.

Description of process and outcome evaluation

The evaluation will consist of both **process** and **outcome** components and will operate at the state, community and program levels. The process component will address the five steps of the Strategic Prevention Framework. Section B of this proposal lays out the key actions that will be taken in relation to the five steps for both the state and local levels. The process evaluation will ask:

1. How closely did the implementation match the state plan?
2. What types of deviation from the plan occurred?
3. What led to the deviations?
4. What impact did the deviation have on the intervention and evaluation?

The outcome evaluation will provide data to measure changes in the national outcome domains and the relationship between changes in the outcomes and the implementation of the Strategic Prevention Framework. Outcome evaluation questions include:

1. What was the effect of the Strategic Prevention Framework on service capacity and other infrastructure objectives?
2. Did the Strategic Prevention Framework project achieve the intended project goals?
3. What program and contextual factors were associated with outcomes?
4. What individual factors were associated with outcomes?
5. How durable were the effects?

The ultimate goal of this project is to create and support a statewide prevention infrastructure that will identify and fund communities based on epidemiological analysis and needs assessment to implement evidence-based and culturally competent prevention programs. These programs in turn will improve prevention outcomes. The strategy of the evaluation plan is to use qualitative material such as interviews, observations, surveys and document reviews in the process evaluation and to use

objective, standardized tools such as MYDAUS and the Youth Tobacco Survey for the outcome evaluation. Results of the process evaluation will be used to explain the outcomes and to guide program enhancements over the course of the project. The table below shows the specific performance measures and target outcomes related to the goals and objectives identified in Section B of the Project Narrative. It also shows the source of the data the evaluator will use for measurement.

Goals, Objectives, Performance Measures and Target Outcomes

Goals and Objectives	Performance Measures	Target Outcomes	Data Source
Goal: Build Maine's Infrastructure and Prevention Capacity			
Identify high need areas/ subpopulations within state based on epidemiological analysis	Municipalities with no prevention services; Risk/protective factors; Health disparities	▪ 20% of municipalities (99) with highest need identified through epidemiological research	Multiple including but not limited to: Census Bureau of Health Housing data UCR Data Crime and Justice Data Book Maine Statistical Analysis Center data
Develop local needs assessments and strategic plans	Common structure developed; Plans completed	▪ Common structure developed; ▪ 100% plans completed	Documents, e.g., local statistical data and plans
Create consistent cross-disciplinary prevention infrastructure at local and regional level	Coordinated funding/distribution process; Evidence-based	▪ 100% of funds distributed based on need, cost effectiveness and evidence-based	Proposals Project budgets
Increase number of communities that coordinate funding from multiple state programs	United Governance Structure Developed	▪ 10 communities with United Governance Structure	Proposals Project budgets Other Documentation
Increase number of communities that implement evidence-based prevention programs	Communities with evidence-based programs	▪ 50% increase over baseline of communities with evidence-based programs	Performance Based Prevention System (PBPS) by KIT Solutions
Develop and implement cross-disciplinary Prevention Workforce Development Plan	Prevention Workforce Development Plan	▪ 1 statewide plan developed	Documents
Goal: Improve Outcomes on Federal GPRA Measures			
Abstinence from Drug Use/Alcohol Abuse	30-day substance use; Availability of alcohol; tobacco and other drugs; Perception of drug use as harmful; Perception of drug us as wrong	▪ Decrease perceived access to alcohol among 6-12th graders by 10%; ▪ Increase perceived consistency of underage drinking enforcement by 10%; ▪ Reduce 2-week binge drinking among 6-12th graders; on college campuses; and among 18-24 year olds by 5% ▪ Reduce average age of first drink among 6-12th graders by 10% ▪ Increase perceived risk of regular/heavy smoking by 10%; ▪ Decrease perceived access to tobacco by 10%; ▪ Reduce 30-day cigarette use by 10%;	Maine Youth Drug and Alcohol Use Survey (MYDAUS) Youth Tobacco Survey Youth Risk Behavior Survey (YRBS) Parent Survey Maine Behavioral Risk Factor Surveillance System (BRFSS)

Goals and Objectives	Performance Measures	Target Outcomes	Data Source
		▪ Reduce heavy smoking by 5% ▪ Increase perceived risk of regular marijuana use by 10% among 6th-12thgraders; ▪ Reduce 30-day and heavy marijuana use by 10%; ▪ Increase proportion of youth who report no 30-day and lifetime use of substances by 5%	Evidence-based program evaluation tools
Increased/Retained employment or return to/stay in school	School attendance ATOD-related suspensions/ expulsions Drug-related workplace injuries	▪ Decrease drop out rate by 10% in targeted communities ▪ Decrease ATOD expulsions by 10% in targeted communities	Department of Education
Decreased Criminal Justice Involvement	Drug-related crime	▪ Decrease drug-related crime by 10% in targeted communities	UCR Data Crime and Justice Data Book Maine Statistical Analysis Center
Increased Stability in Family and Living Conditions	Parent participation in prevention activities	▪ Increase parent participation in prevention activities by 20% in targeted communities	Performance Based Prevention System by KIT Solutions
Increased Access to Services	Number of persons served by age, gender, race and ethnicity	▪ Increase access to services by 10% in targeted communities	Performance Based Prevention System by KIT Solutions
Increased Social Supports	Under development	TBA	PBPS
Goal: Use Cost-effective Evidence-based Practices (other Federally-required measures)			
Cost effectiveness	Increased services provided within cost bands	▪ 75% of services provided within cost bands	Performance Based Prevention System by KIT Solutions
Use of evidence-based practices	Number of evidence-based programs and strategies funded	▪ 100% use of evidence based practices in targeted communities	Performance Based Prevention System by KIT Solutions

The evaluation will operate at three levels: state level; community level; and program level.

State level: The major state-level research questions are: Was there a statewide needs assessment which collected and analyzed epidemiological data that included specified dimensions such as magnitude of substance abuse and related mental health disorders and assessment of risk and protective factors? Did the State engage stakeholders to address needs? Using needs assessment data, was a strategic plan developed encompassing specific dimensions such as targeted priorities, vision of prevention activities and needed infrastructure? Were the activities tailored appropriately to address the needs of different cultural groups? Did the State provide the necessary support to local communities in selecting policies and prevention practices to implement? Did the state monitor and support local training, technical assistance and evaluation activities? Did these activities affect statewide rates on key outcome measures? State level process questions will be answered through interviews, surveys and document review conducted semi-annually. State level outcome questions will be answered through standardized surveys such as MYDAUS and the Youth Risk Behavior Survey analyzed at the statewide level as well as through measures identified by the Epidemiological Workgroup. These analyses will be performed annually or as data becomes available.

Community level: The community level evaluation will represent the high-need communities who are funded to implement programs. At the community level the process questions that will be asked are: Did the community engage in a broad-based local strategic planning process that yielded a prevention plan with multiple strategies? Were both environmental and individual strategies envisioned? Did the plan incorporate tailored strategies to address the needs of different cultural groups? How did the community organize itself to deliver the programs envisioned in the plan? Does the plan include an effective mix of universal, selective and indicated strategies? Targeted outcomes related to smoking, drinking, drug use, school retention, criminal justice involvement, stability in family and living conditions, and service access will be measured at the community. Community level process questions will be answered through interviews, surveys and document review, performed annually. Community level outcome questions will be answered through standardized surveys. These analyses will be performed annually or as data becomes available.

***Program Level*:** Program level evaluation will examine the types of programs mounted in particular communities, the fidelity of program implementation and the resulting changes in program participants. At the program level the kinds of process questions that will be asked are: What programs were identified and what were actually implemented? Were programs implemented according to the design? How many people were targeted and in what domains? How many were actually served? Were the services culturally competent? Program level process questions will be answered through analysis of data entered into PBPS or an enhanced equivalent program, program fidelity questionnaires and program observation. Program level outcomes will look for changes in the attitudes, perceptions and behaviors of those who were touched by the program. Either a standardized Youth Survey with the appropriate domains included, or individual surveys matching the evidence-based practice programs will be used. Instruments will be administered throughout the year as programs are implemented.

Ability to collect and report on required performance measures

Maine has built an excellent infrastructure for data collection through its employment of standard data sources, its participation in national data collection efforts, and its introduction of the PBPS through the SIG project, a program which may be modified or enhanced for future use. The table below shows the federal GPRA measures and the data source that Maine will use.

Federal Measures and Maine Data Sources

Federal GPRA Measure	Maine Data Source
Abstinence from Drug Use/Alcohol Abuse	Maine Youth Drug and Alcohol Use Survey (MYDAUS) Youth Tobacco Survey Youth Risk Behavior Survey (YRBS) Parent Survey Behavioral Risk Factor Surveillance System
Increased/Retained Employment or Return to/Stay in School	Department of Labor Department of Education
Decreased Criminal Justice Involvement	UCR Data Crime and Justice Data Book Maine Statistical Analysis Center
Increased Stability in Family and Living Conditions	Performance Based Prevention System by KIT Solutions
Increased Access to Services	Performance Based Prevention System by KIT Solutions
Increased Social Supports	Performance Based Prevention System by KIT Solutions
Cost Effectiveness	Performance Based Prevention System by KIT Solutions
Use of Evidence-Based Practices	Performance Based Prevention System by KIT Solutions

The State administers the MYDAUS to sixth to twelfth graders in participating school districts, most recently in February 2004 in 342 schools, or 80 percent of eligible schools with a student response rate of 73 percent. In addition, the Youth Risk Behavior Survey is administered every two years to a small valid random sample representative of 6-12th graders. These two sources provide excellent information on both behaviors and attitudes of youth toward alcohol, drug and tobacco use. OSA has also commissioned a phone survey on parental perceptions and attitudes towards their children's use of various substances. The State participates in the CDC's Behavior Risk Factor Surveillance System which contains health-related modules relevant to this evaluation, including a CDC-developed binge drinking module. Other sources of data are state agencies which publish statistics on school graduation and drop out rates, criminal justice activity involving substances, and employment rates by community. Maine also has purchased KIT Solutions for its current SIG project, an excellent source of programmatic information, particularly related to evidence-based practices.

Plans for data collection, management, analysis, interpretation and reporting

***Process Evaluation*:** Data collection will occur through quarterly interviews of the stakeholders at the state level (SPF Advisory Council, Strategies for Healthy Youth Workgroup) and semi-annual interviews with funded groups at the local level. Interviews will be supported by the review of documents including meeting minutes, plans, newspaper articles and other information supporting the local needs assessment and planning effort. As the project progresses, the local evaluation will include observations of programs through semi-annual site visits. The analysis of information regarding state-level processes is primarily descriptive and qualitative. Its purpose is to summarize activities and progress of the state-level planning and implementation effort and, at the end of each year, to answer the questions raised above. At the local level, the analysis will determine, among other questions, what factors are helping and impeding recipients from developing local prevention plans, who was involved in the planning and how, what groups were targeted, what evidence-based practices were employed and why. The demographic characteristics of the community including its racial, ethnic and cultural composition will be among the factors used in interpreting the results. Evaluation findings will be reported through monthly meetings with the project director and monthly progress reports prepared by the evaluation team. These reports, along with other observations and summary analyses, will be incorporated into reports submitted to CSAP. The evaluators will prepare an annual report providing process information at both the state and local levels.

***Outcome Evaluation*:** Analysis of the community-level outcomes will be based on examining changes in targeted outcome measures between the baseline year and the follow-up years. Analysis of program-level outcomes will involve comparisons of pre-test and post-test measures associated with selected evidence-based practices. When there are differences between pre- and post-test scores, appropriate tests will be administered to see if the results are statistically significant. Statistical procedures will also be used to correctly accommodate the clustered nature of the student survey data. While the design does not use formal control groups, the community level results will be compared to non-participating communities with statistical controls applied to compensate for demographic differences. Data will be reported via monthly reports from the evaluator to the state and semi-annual reports to CSAP. Data files will be made available to CSAP and to the national cross-site evaluators as appropriate.

Existing data collection system The existing system is described above (ability to report on required performance measures). It includes data collected and published by the Bureau of Health, the Office of Substance Abuse, the Department of Education, the national Centers for Disease Control and other related agencies. The PBPS is a good organizing database for prevention activities

but it is limited at the current time to those communities with One ME (SIG) Coalitions, although it could be expanded in the future. The other sources have a broader base but each data collection method has its own auspices and timeframes. As a whole, the system is effective in providing the data needed for the key indicators identified at both the state and national levels. It is expected that the SHY workgroup infrastructure development tasks will also enhance and streamline the state's data collection system.

Approaches to Surveying Participants, Gathering Data and Mapping Results The planned approaches include the collection of process information that is new to this project and the collection of outcome information, some of which is already in place (the standardized surveys) and some of which is partially in place but will be enhanced through this project (i.e. testing on evidence-based practices in the communities where those practices are mounted).

***MYDAUS*—**MYDAUS is administered annually to sixth to twelfth graders; results are published and placed on the web. As discussed earlier, around 75,000 students participated in 2004.
Youth Risk Behavior Survey*—** Youth Risk Behavior Survey is administered every two years to a small random sample which is almost always valid and representative of seventh to twelfth graders. ***Parent Survey*—** OSA has administered this telephone survey of 500 parents for several years to assess attitudes and perceptions of youth high risk behaviors. ***Behavioral Risk Factor Surveillance System*—**This telephone survey administered to adults by the U.S. Centers for Disease Control and Maine Bureau of Health includes core sections on health status, exercise, tobacco use, alcohol consumption, home environment, smoking cessation, secondhand smoke, and other areas of interest to this evaluation. The evaluator will focus on the data related to18 to 24 year olds and other high risk populations as they are identified in the epidemiological analysis. ***Interviews*—**Interview guides established for Maine's first SIG project will be modified to ascertain factors affecting community development of prevention infrastructure. The interview guides will contain questions relating to the five steps in the SPF framework. ***Evidence-based Practices—Maine has developed a standard Youth Survey for participants in its current SIG-funded programs. This instrument is modularized based on the CSAP domains that are reflected in the implemented program. This instrument can be expanded to include new age groups or domains identified by SPF-SIG.

Ability to access target populations for gathering data In most of the statewide sources, e.g., the parent survey, all populations are accessed randomly. In the MYDAUS, the entire population of sixth to twelfth graders is targeted but the survey is administered only in communities that agree to participate. (Note: if a community is selected for SPF-SIG that is not currently participating in MYDAUS, it will be required to do so in 2006 to establish a baseline.) For the PBPS the particular communities who are selected for prevention activities are selected. As such, each data source has a different way of targeting people.

Project-specific data collection instruments The table below depicts the project-specific data collection instruments by the evaluation level (state, community, program) and evaluation type (process and outcome). Examples of the instruments appear in the appendix.

Data Collection Instruments by Evaluation Type and Level

	State Level	Community Level	Program Level
Process	SPF Advisory Council Interview Epidemiology Workgroup Survey Strategies for Healthy Youth Workgroup Survey	UGS Coalition Member Survey and Interviews	• Site Observation • Fidelity of Evidence-based Program • PBPS

Outcome	• Parent Survey • MYDAUS • Youth Tobacco Survey • Youth Risk Behavior Survey	• Parent Survey • MYDAUS • Youth Tobacco Survey • Youth Risk Behavior Survey • Environmental Survey	• Evidence-based Program Pre and Post-Tests e.g., All Stars, Parenting Wisely, Across Ages • Youth Survey

Reliability and Validity of Evaluation Methods and Instruments

All proposed outcome instruments have been thoroughly tested for reliability and validity prior to the current project. For example, MYDAUS was developed by SDRG at the University of Washington, based on Hawkins and Catalano's Communities that Care Survey, and validated through a rigorous statistical analysis process to show that the results were indicative of the behaviors reported. In addition, the evidence-based program evaluations have met SAMHSA's rigorous standards. One of the criteria is that the program would have been tested in multiple environments using common instruments and would have been shown to have an effect reaching a level of statistical significance. These programs state the gender and age to which the programs are targeted.

Plan for Tracking Data Over Time

Two methods will be used to track data over time: KIT Solutions and a database that HZA has already developed for the SIG project to organize the administration of surveys and other evaluation tools. Both programs will be examined to determine which is most logical to enhance in order to track data generated by the project over time.

Approach to Ensure Adequate Evaluation and Data Collection Capacity

Maine's SPF-SIG will provide KIT Solutions to all funded communities to ensure adequate evaluation and data collection capacity. In addition, it is the responsibility of HZA, the evaluator, to work with local programs to enhance their knowledge and capacity to use evaluation data at the community level. HZA has successfully performed this function with Maine's SIG grant over the past two years. HZA performs many functions to build local capacity. First, it conducts statewide training to orient people to the evaluation requirements and processes. Second, it conducts follow-up audio and video conferences with community representatives on specialized topics such as evaluating environmental strategies. Third, it provides Help Desk support for KIT Solutions using a 1 800 number. Fourth, it works at community sites on a one-to-one basis to share evaluation findings and explain results. These types of activities will continue in the proposed SPF-SIG project.

Commitment to Meet Requirements of Cross-site Evaluation

The Maine project is committed to participating in and meeting the requirements of the SPF-SIG Cross-site Evaluation. Maine SPF-SIG staff will work cooperatively with CSAP and the national cross-site evaluator in ensuring that the necessary data are collected and that new national measures are incorporated as they may be defined.

End Notes

[i] The most recent year for which state-level estimates are currently available is 2001.

[ii] The data for risk/protective factors in the MYDAUS were computed as cut-points, which are defined as the point at which a score on the scale predicts negative outcomes. The percentages in this table represent the proportion of students whose answers to a series of questions on each factor scored were higher (for risk factors) or lower (for protective factors) than the cut-point for that factor, and thus predictive of future drug/alcohol use.

[iii] *as of July 1, Department of Health and Human Services*

[iv] Letters of Agreement reflecting a commitment by all of these state partners (as well as others) to participate fully in the SPF-SIG project are included in Appendix 1.

[v] Source: Maine Quickfacts, U.S. Census Bureau: State and County QuickFacts.